Data Element Definition (Continued)

Element Name: **NAS Exception Reason (Continued)**

	Order	NAS Exception Reason	Description
Code/Value Specifications (Continued)	11th	L	Hospice
	12th	Q	Active Duty Claims
Algorithm	N/A		

Subordinate and/or Group Elements

Subordinate	Group
N/A	Processing Code

Notes and Special Instructions:

[1] ***Required if applicable to HCSR as defined in NAS Exception Reason Specifications. If not applicable, report blank.***

[2] ***When using single digit codes, left justify and blank.***

Data Element Definition

Element Name: **Nonavailability Statement (NAS) Number**

Records/Locator Numbers

Record Name	Locator #	Occurrences	Required
Institutional	1-110	1	Yes[1]
Non-Institutional	2-110	1	Yes[1]

Primary Picture (Format) Eleven (11) alphanumeric characters

Definition Unique number assigned by the MTF when issuing the NAS. This number is carried on the DEERS database.

Code/Value Specifications Submit in same format as DEERS response. Code 46000000000 when reporting NAS on file and copy of NAS is not attached to the claim. Code 47000000000 if HCSR is complete denial for other than Nonavailability Statement not provided. (Codes 46000000000 and 47000000000 are valid for HCSRs with a Date of Admission/Begin date of care < 11/1/92.) Code 46000000000 will continue to be valid if Filing State/ Country Code is not numeric and ≠ 'PR'.

Algorithm N/A

Subordinate and/or Group Elements

Subordinate	Group
N/A	N/A

Notes and Special Instructions:

[1] ***Download field from DEERS (or from hardcopy if attached to claim). Required if inpatient care and patient lives within a catchment area, or outpatient care for selected outpatient procedures (see Policy Manual, Chapter 11, Section 2.1.) and patient lives within a catchment area. Can be blank if the record is denied for lack of NAS, or HCSR contains treatment data exempt from NAS requirement (refer to NAS Exception Reason [1-180, 2-180]).***

Data Element Definition

Element Name: **Number of Births**

Records/Locator Numbers

Record Name	Locator #	Occurrences	Required
Institutional	1-290	1	Yes[1]

Primary Picture (Format) One (1) signed numeric digit.

Definition Number of births, both live and stillborn, occurring during delivery.

Code/Value Specifications Use V Codes to define 1, 2 or multiple births. Number of births must agree with the diagnosis code. If the actual number of births is present on the claim form or supporting documents, it must be reported accordingly. Only in those cases where this is not available, report the number of births as follows:

V27.0 - V27.1	1 birth
V27.2 - V27.4	2 births
V27.5 - V27.7	3 births or more
V27.9	1 birth or multiple
651.80, 81, 83	5 births
651.91	3 births

Algorithm N/A

Subordinate and/or Group Elements

Subordinate	Group
N/A	N/A

Notes and Special Instructions:

[1] ***Required for delivery. Reported on the mother's HCSR only.***

Data Element Definition

Element Name: **Number of Payment Reduction Days/Services**

Records/Locator Numbers

Record Name	Locator #	Occurrences	Required
Institutional	1-207	1	Yes[1]
Non-Institutional	2-212	1	Yes[1]

Primary Picture (Format) Three (3) signed numeric digits.

Definition Number of Payment Reduction Days/Services[2] Assessed.

Code/Value Specifications N/A

Algorithm N/A

Subordinate and/or Group Elements

Subordinate	Group
N/A	N/A

Notes and Special Instructions:

[1] *If not applicable, zero fill.*

[2] *For Institutional records, number of payment reduction days shall be reported. For Non-Institutional records, number of payment reduction days for partial hospitalization program or number of provider services shall be reported.*

Data Element Definition

Element Name: **Number of Services**

Records/Locator Numbers

Record Name	Locator #	Occurrences	Required
Non-Institutional	2-300	Up to 25	Yes

Primary Picture (Format) Two (2) signed numeric digits.

Definition Number of procedures performed/services or supplies rendered for medical, dental, and mental health care.

Code/Value Specifications N/A

Algorithm Identical procedures must be combined when performed by the same provider, with the same charge for each, and within the same calendar month, provided the reason for allowance/denial is the same for each charge. For ambulance services, allergy testing, DME rental, POV mileage for PFPWD, or anesthesiology, enter 01 for each service regardless of length of time, number of base units or mileage. Allowed prescription drugs must be combined separately from disallowed prescription drugs. For prescriptions report the number of prescriptions.

Subordinate and/or Group Elements

Subordinate	Group
N/A	N/A

Notes and Special Instructions:
N/A

Data Element Definition

Element Name: **Occurrence Number**

Records/Locator Numbers

Record Name	Locator #	Occurrences	Required
Institutional	1-385	Up to 50	Yes
Non-Institutional	2-335	Up to 25	Yes

Primary Picture (Format) Two (2) unsigned numeric digits.

Definition A unique number for each utilization/revenue data occurrence within the HCSR. Occurrence numbers must be assigned in sequential ascending order.

Code/Value Specifications N/A

Algorithm N/A

Subordinate and/or Group Elements

Subordinate	Group
N/A	N/A

Notes and Special Instructions:

N/A

Data Element Definition

Element Name: **Override Code**

Records/Locator Numbers

Record Name	Locator #	Occurrences	Required
Institutional	1-170	1	Yes[1]
Non-Institutional	2-170	1	Yes[1]

Primary Picture (Format) Six (6) alpha characters.

Definition Code that provides indication that questionable information has been verified

Code/Value Specifications

A Patient is over 65

B Patient is a spouse under 12 years of age

C Good faith claim; payment has been made. See COM-FI Part Two, Chapter 1, Section IV.B., Section IV.C., and Section IV.D., (for FIs) or OPM Part Two, Chapter 1, Section IV.B., Section IV.C., and Section IV.D., (for Contractors)

D Patient is dependent 21 years of age and over 18 for VA

E Diagnosis is maternity; patient is under 12 years of age

F Claim was filed after the filing deadline. See COM-FI Part Two, Chapter 1, Section IV.B., Section IV.C., and Section IV.D., (for FIs) or OPM Part Two, Chapter 1, Section IV.B., Section IV.C., and Section IV.D., (for Contractors)

G Diagnosis/Procedural code for female; sex indicates male

H Diagnosis/Procedural code for male, sex indicates female

Notes and Special Instructions:

[1] ***Required if override code is applicable to override OCHAMPUS edit checking. Can report 1 to 3 codes, left justify and blank fill. Do not duplicate. Each code is two characters: left justify and blank fill***

Data Element Definition

Element Name: **Override Code (Continued)**

Code/Value Specifications (Continued)

I	Patient is a former spouse under 34 years of age
J	Successive admission (patient is dependent of an Active Duty Sponsor and cost-share is based on both current and prior admission)
K	Catastrophic loss protection limit reached, patient cost-share and deductible rules do not apply
L	Non-DRG reimbursement using DRG-related cost-share calculation 1988 DoD Appropriations Act
M	NATO, Social Security Number not applicable
N	Retrospective payment - Inpatient Mental Health
O	Government payment penalties applied
P	Reserved (to be used only with OCHAMPUS authorization)
Q	Former Spouse with Pre-Existing Condition
R	Patient date of birth is not consistent with procedure/diagnosis code age restricting; procedure performed due to medical necessity
S	Zip code override to be used when a beneficiary has moved out of a region and the FI/Contractor is still responsible for the care claimed.
T	MHPD Recalculation of rates, no cost-share applied
U	Beneficiary indemnification payment
V	Active Duty Dependent, services provided in OCHAMPUSEUR

Notes and Special Instructions:

1 ***Required if override code is applicable to override OCHAMPUS edit checking. Can report 1 to 3 codes, left justify and blank fill. Do not duplicate. Each code is two characters: left justify and blank fill***

Data Element Definition

Element Name: **Override Code (Continued)**

Code/Value Specifications (Continued)

Y Newborn in mother's room without nursery charges

Z Enhanced benefit (CRI Contractors only)

Algorithm N/A

Subordinate and/or Group Elements

Subordinate	Group
N/A	N/A

Notes and Special Instructions:

1 ***Required if override code is applicable to override OCHAMPUS edit checking. Can report 1 to 3 codes, left justify and blank fill. Do not duplicate. Each code is two characters: left justify and blank fill***

Element Name:	Reason for Payment Reduction (1-113)

Validity Edits

1-113-01 MUST BE 'A', 'B', 'C' OR BLANK.

Relational Edits

Related to Element	Edited Element Relationship	Also Relates to Element(s)
AMOUNT OF PAYMENT REDUCTION	SEE BELOW	
NUMBER OF PAYMENT REDUCTION	SEE BELOW	
NUMBER OF PAYMENT REDUCTION DAYS/SERVICES	SEE BELOW	

Edited Element Relationship

1-113-02R IF AMOUNT OF PAYMENT REDUCTION IS NOT EQUAL TO ZERO AND NUMBER OF PAYMENT REDUCTION DAYS/SERVICES IS NOT EQUAL TO ZEROS.
REASON FOR PAYMENT REDUCTION MUST NOT BE BLANK.

1-113-03R IF ENROLLMENT STATUS EQUALS 'T', 'U', 'V', *OR 'Z'*.
REASON FOR PAYMENT REDUCTION MUST BE 'A', 'B', 'C', OR BLANK.
ELSE
REASON FOR PAYMENT REDUCTION MUST BE 'A', 'B', OR BLANK.

Element Name: Amount Billed (1-115)

Validity Edits

1-115-01 MUST BE NUMERIC

Relational Edits

Related to Element	Edited Element Relationship	Also Relates to Element(s)
TYPE OF SUBMISSION	SEE BELOW	FILING DATE
REVENUE CODE	SEE BELOW	TOTAL CHARGE BY REVENUE CODE
PRINCIPAL TREATMENT DIAGNOSIS	SEE BELOW	TYPE OF SUBMISSION, SPECIAL PROCESSING CODE
AMOUNT ALLOWED	SEE BELOW	SPECIAL RATE CODE, TYPE OF SUBMISSION, FILING DATE, ENROLLMENT STATUS
SPECIAL PROCESSING CODE	SEE BELOW	FREQUENCY CODE, TYPE OF SUBMISSION, FILING DATE

Edited Element Relationship

1-115-02R AMOUNT BILLED MUST BE > ZERO **WHEN**:

TYPE OF SUBMISSION	I	INITIAL SUBMISSION
	R	RESUBMISSION OF ERROR REJECT
	O	ZERO PAYMENT
	F	ADJUSTMENT NEW SUFFIX
	D	COMPLETE DENIAL
	G	ADDITIONAL DRG INTERIM BILLING

OR

TYPE OF SUBMISSION	A	ADJUSTMENT
	C	COMPLETE CANCELLATION

WITH FILING DATE WITHIN THE NUMBER OF MONTHS OF HCSRs STORED ON THE DATABASE.

1-115-03R AMOUNT BILLED MUST = TOTAL CHARGE BY REVENUE CODE FOR REVENUE CODE 001.

1-115-04R AMOUNT BILLED MUST BE ≤ $50.00 **WHEN** PRINCIPAL TREATMENT DIAGNOSIS EQUALS 799.9.

UNLESS TYPE OF SUBMISSION	D	COMPLETE DENIAL
OR ANY OCCURRENCE OF SPECIAL PROCESSING CODE	1	MEDICAID

1-115-05R AMOUNT BILLED MUST BE ≥ AMOUNT ALLOWED **WHEN**:

ENROLLMENT STATUS	F	FI STANDARD CHAMPUS
	D	MANAGED CARE SUPPORT - TRICARE-TIDEWATER STANDARD CHAMPUS PROGRAM